MDR Tracking Number: M5-04-2726-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 4-26-04.

Per telephone conversation with ___ from the health care provider's office on 9/28/04, the insurance carrier paid for CPT code 20550 and 99080-73. The parties agreed to accept the payment as payment in full. Therefore, these items will not be addressed in this review.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises, myofascial release, therapeutic procedures, unlisted therapeutic procedures, ultrasound, hot/cold packs therapy, massage therapy, and office visits from 5/13/03 through 6/4/03, 6/24/03 and 7/16/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, the request for reimbursement for dates of service 5/13/03 through 6/4/03, 6/24/03 and 7/16/03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this1st day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

July 1, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected services in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-2726-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: office notes, TWCC-73, referrals, treatment log, Rx, RME, consultations and evaluations.
Information provided by Respondent: correspondence and peer reviews.

Clinical History:
This is a 53-year-old female. Date of injury is ___, reporting an 8 out of 10 pain scale with numerous surgeries to the cervical area, shoulder, and carpal tunnels. The job duties were typing, which she had done for many years.

Disputed Services:
Therapeutic exercises, myofascial release, therapeutic procedures, unlisted therapeutic procedures, ultrasound, hot/cold pack therapy, massage therapy and office visits on 05/13, 05/20, 05/23, 05/30, 06/04, 06/24 and 07/16/2003

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
The rationale or basis for decision is based on medical documents that were provided. After reviewing peer-reviewed literature and 5 previous peer reviews, I am in agreement that the dates of service and modalities were an over-utilization of treatment in this patient and denied based on the lack of objective documentation to support progression.

This patient originally presented to her treating doctor with an 8 out of 10 pain scale. Four years later the patient is at a 7 out of 10 on the pain scale. There is lack of objective documentation to support progression that these modalities are more palliative in nature. The therapeutic exercise/procedures and the myofascial release should be given more as a home-based activity level for the patient to continue at home. The ultrasound therapies, again, were more palliative. Hot/cold pack therapies can be an application done by the patient with home instructions. The massage therapy, again palliative, although does offer some benefit as far as scar tissue. This massage therapy can be done by the patient on the various scar sites of the shoulders and wrists.

Again, with the protracted amount of time of treatment therapy and multiple surgeries on these areas, the patient has shown no progression during that 4-year span from the time of injury to the last visit in 2004. Several surgical sites would have scar tissue. The patient, more or less, could undergo psychological evaluation for pain management/ Biofeedback.